Notes of a meeting held on 6 February 2017 at 3.10pm in Chief Executive Office, Countess of Chester Hospital

Present:	Sue Letby (SL)	
	John Letby (JL)	
	Lucy Letby (LL)	
	Hayley Cooper (HC)	FCN Representative
	Karen Rees (KR)	Head of Nursing, Urgent Care
	Tony Chambers (TC)	Chief Executive
	Ian Harvey (IH)	Medical Director/Deputy Chief Executive
	Alison Kelly (AK)	Director of Nursing & Quality
	Sue Hodkinson (SH)	Director of People & Organisational Development

TC Welcome everyone to the meeting. We promised we would regroup when we had the final report. We have received all of the outcomes for the reviews of all outcomes, 13 babies, over an 18 month period. We have explanations for the majority, but sometimes we don't get answers.

We have held a Board meeting, reviewed the information and shared your statement. It was a tough meeting. We also met with the paediatricians, sharing the headlines of the report and your statement. It was a similar meeting. They will receive a copy of the report, as will the families. The report was leaked to the Sunday Times; which is understandable, as the families of the 13 babies felt they were in the dark.

All aspects are coming together.

It has been very tough for everybody, especially you Lucy. The paediatric doctors raised concerns, we have discussed the way those concerns were raised and the unprofessional behaviour; your statement said it all. We are now ready to share the report. We have a clear assurance from the paediatricians that they will write an apology to you.

LL Will this be from all 7 consultants?

TC An apology from the whole consultant team, it will be done as a group.

LL Why is that?

TC It is thought to be the most sensible. We have recognised some of their behaviour was not appropriate. This is acknowledged and we need to get to a position where we can move forward and get you back to work within the

Neonatal Unit, through mediation. We can take forward the recommendations, there are 24 of them, with no single casual factor. There are a range of things.

SL How will the mediation happen?

SH It is arranged through our Occupational Health Team and we commission Cheshire & Wirral Partnership (CWP) to do this. The two members of staff will be met with separately, meeting you first, and then all meeting. Kathryn is looking to arrange this early March, based on the mediator's availability.

LL I expect four apologies.

SL It is unacceptable if not.

TC They've all agreed. They are keen, and we are, for Lucy's benefit to draw a line. The important part is a collective apology; I'm not sure what is to be gained making it so personal.

JL/LL/SL It is easier to do a collective apology – they made it very personal against her, personal allegations and redeployed; she's not been told about it.

TC What does success look like for you? To get back to the unit.

LL It is one of the points agreed in the grievance.

TC The report may have been shared by family members through the coroner. We don't want further harm for you, for it to be about you and not about the mortality of the babies. My advice is that this is the best way forward. There is plenty of blame on all parts; whilst it might help, it may not help your transition to the unit.

SL We're not getting the outcome of the grievance though, we were expecting four apologies.

JL The report has been leaked to the press. What I'm concerned about is because people know Lucy was removed from NNU, was she to blame.

TC The report makes no references to you at all. It focuses on the relationships between doctors and nurses, delayed decision making. If we pursue the other line, it becomes about you and that's where the risk may sit. It talks about culture, leadership, comms - you won't see yourself in it. A collective apology may be better. I was concerned when you wrote to colleagues as we can't control what may get out.